Clinical Services

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby give my permission for the ACES Clinical Services to view information and/or verbally confer with the following professionals regarding my child's IEP. The purpose of such exchange is to provide the ACES staff with current and relevant medical and/or therapeutic information which may impact the student's educationally related services. Providers outside of his/her educational program would be given information regarding the student's school based therapeutic assessment, goals, objectives, and progress. Exchange may include: evaluations/assessments, testing, and reports.

Student's Name: ______________________ **Date of Birth:** ______________

School District/School: ____

Please include current primary physician and any other outside/agency providers (i.e. occupational therapist, physical therapist, speech/language pathologist, etc.):

Physician: ____

Address: ____

Phone: ____

Email: ____

Name: ____

Profession: ____

Address: ____

Phone: ____

Email: ____

Name: ____

Profession: ____

Address: ____

Phone: ____

Email: ____

Name: ____

Profession: ____

Address: ____

Phone: ____

Email: ____

______________________________ ______________________

Parent/Guardian (Please print) **Home phone**

______________________________ ______________________

Signature of Parent/Guardian **Date**